Substance Abuse Treatment for Inmates with Co-Occurring Disorders in New York State Prisons

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Abstract

This article reports the results and recommendations contained in a section of the Correctional Association of New York (CA) report, ***Treatment Behind Bars: Substance Abuse Treatment in New York Prisons, 2007-2010****, concerning the provision of substance abuse treatment for New York State prison inmates who have co-occurring disorders (COD) involving mental health and substance abuse treatment needs. The three-year study culminating in the CA report investigated substance treatment for all New York State inmates, including those with COD who were treated in general substance abuse treatment programs and integrated mental health and substance abuse treatment programs in the state's prisons. The article describes the various substance abuse treatment programs in the general prison population, disciplinary confinement units, and residential mental health units. The article explains the assessment process for placement of inmates in prison treatment programs and reports on the perceptions of COD inmate program participants who were enrolled in prison treatment programs. The study found that more integrated treatment programs are needed to meet the needs of the prison*

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population, enhanced training should be provided to the treatment staff, and improved discharge planning is required for COD program participants who are being released from prison or completing the program and returning to the general prison population.

Keywords: Co-occurring disorders, New York, substance abuse, treatment

The prevalence of co-occurring mental illness and substance abuse is a relevant and widespread issue for both individuals suffering from these conditions and providers in the community, and even more so in the prison system. A 2008 study done by the Office of Applied Studies (OAS) in the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services estimated that 8.9 % of the U.S. population aged 12 and older was classified with substance dependence or abuse during the study year based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSMIV) (Substance Abuse and Mental Health Services Administration, 2009). The difficulties of dealing with and managing a substance abuse problem alone can be extremely daunting and devastating, and many individuals must cope simultaneously with both a substance abuse problem and serious mental illness. According to SAMHSA, 73% of persons with a drug dependence disorder in substance abuse treatment had a co-occurring mental disorder at some point during their lifetime (Center for Substance Abuse Treatment, 2007).

The New York State Department of Correctional Services (DOCS) reports that 83% of the State's prison population, or approximately 47,850 of the 57,650 inmate population (as of April 2010) are in need of substance abuse treatment (NYS DOCS, 2007). Sixty of New York State's 67 correctional facilities operate a total of 119 substance abuse treatment programs, making DOCS the single largest provider of substance abuse treatment in the State. According to the New York State Office of Mental Health (OMH), 13.4% of the New York State inmate population, about 7,800 individuals, were on the mental health caseload as of January 2010, and 30.2% of the individuals on the mental health caseload have a primary or secondary diagnosis of substance abuse (NYS OMH, Patient Profile, 2010; NYS OMH, Patient Profile, 2007). Due to the high prevalence of inmates with both mental health disorders and substance abuse

treatment needs in New York State prisons, DOCS has become one of the largest providers of both substance abuse and mental health treatment in the State.

DOCS is in a unique position to provide effective treatment to these individuals. Studies have shown that in order to reduce drug abuse and criminal behavior among substance abusers, treatment in the community is more effective than incarceration, and in addition, reduces the recidivism rate among this population (Fletcher and Chandler, 2006). Individuals with co-occurring disorders who receive integrated care, a combination of mental health and substance abuse treatment, are less likely to disengage from their treatment plan and have better post-treatment outcomes (Rothbard, 2009). OMH is tasked with the responsibility of determining which individuals entering DOCS custody are in need of mental health services, but the determination of who will be required to participate in substance abuse treatment is conducted by DOCS during a separate screening process. The absence of a more coordinated screening process between DOCS and OMH results in an increased likelihood that many individuals in New York State prisons who have co-occurring disorders and could benefit from a specialized program are not being identified for these programs.

The Correctional Association of New York (CA), a non-profit, independent advocacy agency with unique legislative authority to enter New York State correctional facilities and monitor conditions of confinement, launched a project in 2007 to evaluate the needs of inmates with substance abuse problems and the State's response to those needs. The CA reviewed system-wide data provided by DOCS and visited 23 facilities, where CA staff interviewed experts, inmates, prison officials and correction officers and collected surveys from 2,300 inmates in prison substance abuse treatment programs or waiting to enroll in such programs. In March 2010, the CA published *Treatment Behind Bars, Substance Abuse Treatment in New York State Prisons, 2007-2010* (www.correctionalassociation.org/publications/download/pvp/issue_reports/satp_report_and_appendix_february_2011.pdf), a comprehensive review of substance abuse treatment programs in the state prisons, including specific findings about existing programs and recommendations to enhance treatment services and to improve treatment outcomes.

Community Treatment Standards for Individuals with Co-Occurring Mental and Substance Use Disorders

Nationally, SAMHSA recommends that the identification of one disorder, either mental health or substance use, should automatically trigger a screening for the other type of disorder given the high rates of co-occurring disorders (COD) among individuals involved in the criminal justice system (Peters, Wexler, and the Center for Substance Abuse Treatment, 2005). In the assessment process, SAMHSA further suggests that a skilled evaluator conduct a joint, rather than separate, assessment of mental health and substance use disorders. This assessment should include an examination of the interaction between symptoms of both disorders to determine whether the individual's mental health condition is present independent of his/her substance use, whether it is contingent on that person's use of a controlled substance or whether the individual's substance use is merely mimicking symptoms of a mental disorder. It is also possible that mental health conditions previously masked by an inmate's substance use emerge only after he/she attains abstinence, or that an individual experiences heightened depression or anxiety in the early stages of recovery as a result of his/her withdrawal. For these reasons, mental health assessments of individuals identified as in need of substance abuse treatment should occur regularly throughout the treatment process, not just during the initial screening period.

Numerous tools and instruments may be used during the screening and assessment process to determine the severity of an individual's mental health and substance abuse issues. Several commonly recommended screening instruments that focus on both substance use and mental disorders include the Addiction Severity Index (ASI), the Global Appraisal of Needs - Short Screener (GAIN-SS) and the Mini International Neuropsychiatric Interview (MINI). These instruments were reviewed by a joint Co-Occurring Center for Excellence (COCE)/Co-Occurring State Incentive Grants (COSIG) Workgroup and found to be reliable, internally consistent and valid (SAMHSA's COCE, 2006). Although the actual criteria for determining whether an individual has a COD varies considerably and encompasses multiple substance-related and mental health diagnoses, the National Association of State Mental Health Program Directors (NASMHPD) and National Association of State Alcohol and Drug Abuse Directors (NASADAD) developed a conceptual framework that classifies individuals into four quadrants based on the relative severity of their substance abuse and mental disorders: less severe mental disorder/less severe substance

disorder, more severe mental disorder/less severe substance disorder, less severe mental disorder/more severe substance disorder, and more severe mental disorder/more severe substance disorder (SAMHSA's COCE, 2006). Each quadrant in the model corresponds to an appropriate level of care, ranging from primary care settings or intermediate outpatient settings for either mental health or substance use programs to intensive, comprehensive and highly integrated programs that address both mental health and substance abuse issues (SAMHSA's COCE, 2006).

In describing the treatment needs of inmates with COD, it is important to emphasize that individuals with dual diagnoses are *not* a homogenous group and have many different mental health and substance use needs that will inevitably influence the effectiveness of any given treatment modality or approach. Some variation among inmates with COD may be attributed to gender differences between males and females in need of substance abuse treatment (e.g., women are more likely than men to be diagnosed with post-traumatic stress disorder (PTSD) or depression) (Farkas & Hrouda, 2007). Although there is substantial literature that indicates the usefulness of targeted interventions for specific populations (e.g., Dialectical Cognitive-Behavioral Therapy has been found to be particularly effective in treating COD individuals with borderline personality disorder, while *Seeking Safety* has shown promise among COD women suffering from PTSD) (Taxman et al., 2008), it was beyond the scope of the CA study to make diagnosis-specific recommendations for treatment. Instead, the CA report addressed the general treatment needs and possible treatment approaches for individuals with COD.

Individuals with COD have been referred to generally as "a particularly vulnerable subgroup with complex service and treatment needs" (Tsai et al., 2009), that merit special attention in the provision of substance abuse treatment programs. As a whole, they are less likely to receive both mental health and substance abuse treatment and more likely to have poorer outcomes in treatment (including low engagement levels and early termination) when they receive care in only mental health or substance use. Without treatment in both areas, individuals with COD are at a greater risk of relapse, suicide, HIV infection, unemployment and poor interpersonal relationships than the general population (Hawkins, 2009). COD individuals involved in the criminal justice system are also particularly susceptible to incarceration or re-incarceration, similar to the way that individuals with co-occurring disorders who are not involved in the criminal justice system are vulnerable to hospitalization or re-hospitalization in the absence of treatment (Cropsey et al.,

2007). Studies have additionally shown that individuals with COD who have committed offenses are at greater risk of acting violently than individuals with mental health disorders alone, with the rate of violent acts increasing proportionate to substance use, thus emphasizing the importance of providing concurrent substance abuse treatment (Cropsey et al., 2007).

Some components of traditional substance abuse treatment programs (e.g., intense encounters) are not conducive to the recovery of individuals with serious mental disorders and may contribute to some of the previously referenced poor treatment outcomes observed among individuals with COD (e.g., low engagement, early termination, etc.). Confrontational services and the rigidity of many traditional substance abuse treatment services, for example, have been found to be overly harsh or impose too many undue restrictions for individuals with mental health diagnoses and can lead to decompensation in some cases (DiNitto, Webb, & Rubin, 2002).

In general, there is a clinical consensus that integrated mental health and substance abuse treatment provides effective ways to produce optimal outcomes for individuals with COD (see, for example SAMHSA TIP 42). *Integrated treatment* refers broadly to any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting. Integrated treatment is a means of actively combining interventions intended to address substance use and mental disorders in order to treat both disorders, related problems and the whole person more effectively (Sacks, Ries, and Center for Substance Abuse Treatment (U.S.), 2005). The settings in which integrated services can be delivered vary from a single provider who identifies and treats an individual's substance abuse and mental health needs through direct contact, to several programs or teams of providers who collaborate to deliver mental health and substance abuse services. Integrated services should be offered to individuals with COD during the screening, assessment, treatment planning, treatment delivery and continuing care phases of any given program. Individuals with COD who receive integrated care in the community are not only more likely to be engaged in their treatment and adhere to their treatment plan, but are also more likely to attend/complete their program and have better post-treatment outcomes (Rothbard et al., 2009).

Treatment programs that appropriately implement a modified therapeutic community (MTC) approach have been found to be useful in a variety of settings, including correctional settings, for individuals with COD, in part because they can provide increased flexibility of programming and a decreased intensity of interpersonal interactions (Sacks, Sacks, & Stommel, 2003). Participants engaged in MTC programs, who also enrolled in integrated aftercare programs, had significantly better outcomes when compared to individuals participating in only mental health treatment programs on measures of re-incarceration (Sacks et al., 2003) and relapse of substance use (Sullivan et al., 2007).

DOCS Programs for Individuals with Co-Occurring Mental and Substance Use Disorders

OMH provides all mental health treatment services available inside New York State correctional facilities, each of which is assigned an OMH level from one to six, with OMH level one facilities housing individuals with the most intensive mental health treatment needs and OMH level six facilities having no mental health treatment programs or staff on site. Fifteen New York State prisons are rated as an OMH level one facility, 11 as an OMH level two facility, 10 as an OMH level three facility, 8 as an OMH level four facility and 25 as an OMH level six facility. Fourteen of the OMH level one correctional facilities in New York State operate a residential Intermediate Care Program (ICP) for individuals with mental health disorders who are unable to manage in the general prison population. Most of these ICP units offer a variety of program and treatment services including substance abuse treatment programs run by DOCS staff. These programs were previously referred to as ICP Alcohol and Substance Abuse Treatment (ICP ASAT) programs and are now labeled ICP Integrated Dual Diagnosis Treatment (ICP IDDT). Individuals housed in the ICP may be required to participate in an ICP IDDT program if identified as having a co-occurring disorder. The CA commends both DOCS and OMH for the strong commitment they have made to providing adequate mental health services for individuals residing in the ICP, and has observed that many inmates in these units report higher rates of satisfaction and feelings of safety and support than their counterparts in general population.

In addition to treatment programs in the ICP, individuals with co-occurring mental and substance use disorders may receive some level of substance abuse treatment in the Behavioral Housing Unit (BHU) or

Special Treatment Program (STP), treatment services for individuals with severe mental health disorders in disciplinary housing. As of August 2009, DOCS reported that these substance abuse treatment programs (e.g., programs for ICP, STP, BHU, and general population inmates with COD) had a combined capacity of 379 inmates. (DOCS also offers a Special Needs Unit (SNU) ASAT program for inmates with developmental disabilities. These SNU ASAT programs operate in two facilities and offer 20 treatment slots. The CA did not have the opportunity or resources to observe or gather specific data from these programs during the course of the study and therefore SNU ASAT programs are not covered in the CA report.)

Although the DOCS' Intermediate Care Program (ICP) manual outlines the admissions criteria for the ICP housing unit, it does not present the criteria used to select which ICP inmates are eligible for substance abuse programming while housed in the ICP unit. With more than 7,800 DOCS inmates on the OMH caseload and only 685 residing in ICP units (NYS OMH, Quarterly Indicator, 2010), the majority of individuals with co-occurring mental and substance use disorders are housed in general population (GP). Only three DOCS facilities operate integrated substance abuse treatment programs for general population COD inmates, previously referred to as Mental Ill/Chemically Addicted (MICA) ASAT and now named GP IDDT.

During a visit to Downstate Reception Facility in November 2009, Correctional Association staff inquired about the substance abuse and mental health screening process for all inmates entering DOCS custody. They found the screening process somewhat vague and the criteria for treatment unclear. Screened inmates are not assessed for severity of need and no distinction is made regarding substance use verses substance dependence. Furthermore, inmates in New York State prisons do not undergo a joint mental health and substance abuse screening process, but rather, are assessed for mental health conditions separately from being screened for substance abuse. While the CA believes that OMH may conduct a separate evaluation and diagnosis of substance abuse, it appears that DOCS is responsible for identifying and placing COD inmates into these specialized substance abuse treatment programs. It appears that no process was in place for communicating information between the two agencies, resulting in a number of individuals who could benefit from a COD program not being identified for placement into such programs.

Treatment for Inmates with Co-occurring Disorders in Residential Mental Health Programs

As discussed above, the ICP IDDT program, offered at 11 facilities, only serves individuals identified by OMH as having an Axis I and/or Axis II DSM-IV mental health diagnosis and placed in a residential mental health treatment program. These ICP IDDT programs have a capacity to serve 157 participants among the total ICP population that can reach a maximum of 737 patients if all units are at full capacity. Most of the ICP IDDT programs the CA visited were not filled to capacity, and these facilities reported no waiting list for the program, suggesting that the needs of most COD ICP inmates were being met at these prisons.

Of the various substance abuse treatment programs offered to inmates with mental health issues in New York State correctional facilities, the ICP IDDT programs are by far the most integrated and appropriate for individuals with co-occurring disorders. ICP IDDT programs involve collaboration between OMH staff and substance abuse corrections counselors and do not use confrontational models, hierarchies, push-ups/pull-ups, or impose strict time limits for program completion, treatment modalities proven not to be ideal for COD individuals. Though DOCS has reported that an updated IDDT program curriculum is used for these programs, the CA was unable to access these materials by the time of publication of its report and is therefore unable to comment on the comprehensiveness of the program.

Treatment for Inmates with Co-occurring Disorders in Disciplinary Confinement

With approximately 5,000 beds in DOCS disciplinary confinement units system-wide, called Special Housing Units (SHU), and a population of 4,350 inmates housed in the 42 prison disciplinary units as of 2009, there is a need to develop treatment programs for disciplinary inmates who are not allowed to participate in the general population substance abuse treatment programs while they are in the SHU. The CA visited many disciplinary units during this study and in its general prison monitoring work and the

percentage of inmates in disciplinary confinement suffering from mental health problems is even greater than the percentage of inmates (14%) on the OMH caseload in general population. For example, at some disciplinary units we have visited, 20% to 50% of the disciplinary inmates are actively receiving mental health care. Similarly, many of the disciplinary inmates also have substance abuse problems, including some of whom have been disciplined for using drugs in the prison, thus resulting in their disciplinary confinement sentence. The majority of DOCS disciplinary inmates either have no access to any substance abuse treatment services or can only use a treatment-readiness workbook. A more comprehensive program and support system is needed, especially for SHU inmates (who often have intense substance abuse and mental health needs).

Individuals with significant mental health or behavioral issues who receive lengthy disciplinary sentences are housed in a few specialized mental health programs throughout DOCS. The Behavioral Health Units (BHU) and the Specialized Treatment Programs (STP) are DOCS residential programs for these inmates. DOCS and OMH jointly operate these programs at Attica, Five Points, Great Meadow and Sullivan Correctional Facilities. Except at Sullivan, there are no interactive substance abuse treatment programs for these COD disciplinary inmates, and residents of these units who are designated as needing substance abuse treatment are only offered a cell-study program guided by a treatment-readiness workbook with very limited interaction with substance abuse treatment staff. The treatment-readiness workbook solely focuses on substance use and does not clearly address the mental health needs of the COD population. In the Sullivan BHU, which houses 60 disciplinary inmates with serious mental illness, treatment staff conduct an ASAT program that is offered to its residents.

Treatment for Inmates with Co-occurring Disorders in General Population

Given that residential substance abuse treatment options for individuals with COD are offered at only a limited number of facilities and only serve individuals with serious mental illness, the majority of inmates with mental health and substance abuse needs live in general population. The two male (Arthur Kill, capacity of 17 and Mid-State, capacity of 42) and one female (Bedford Hills, capacity of 50) correctional facilities that run GP IDDT programs have a combined capacity for only 109 participants, a number clearly

insufficient to meet the needs of COD individuals residing in general population. With 7,800 DOCS inmates on the OMH caseload in 2010, including estimates of approximately 2,500 inmates with serious mental illness, the Department has an extremely large population of individuals who require significant mental health and substance abuse services in general population. Anecdotally, treatment staff in general population substance abuse treatment programs have informed the CA on its visits that addressing the mental health issues of these inmates is one of the greatest challenges they face in their substance abuse treatment programs.

The total capacity of the Department's residential mental health programs for non-disciplinary inmates with serious mental illness is approximately 1,030 beds, well below the number of inmates with serious mental illness. Consequently, 1,300 to 2,000 inmates with serious mental illness live in general population, and many of these individuals have substance abuse histories, given the Department's estimate that 83% of all inmates are identified substance abusers. DOCS' 109 GP IDDT program slots cannot meet this need and most inmates with serious mental illness in general population are either assigned to a regular substance treatment program or prohibited from participating in the many prisons' general population substance abuse treatment programs that do not accept individuals with serious mental illness. One barrier that exists to expanding IDDT programs in general population is the need for greater coordination between OMH and DOCS. In order to run effective GP IDDT programs, some additional OMH resources (e.g., staff) are required. As DOCS does not control these limited resources, the Department would have to work with OMH to identify additional resources and programs for COD inmates in general population.

Inmates with mental health conditions who participate in non-IDDT general population substance abuse treatment programs do not receive the same level of integrated treatment (e.g., trained OMH staff or a curriculum specifically designed for individuals with dual diagnoses). It is well documented that COD individuals who are placed in general substance abuse treatment programs forgo many benefits of integrated care identified by experts, including reduced substance use and improved abstinence, improved mental health symptoms (including fewer suicidal thoughts), and reduced rates of hospitalization, re-incarceration and arrest (Rothbard et al., 2009; Drake, O'Neal, & Wallach, 2008; Smith, Sawyer, & Way, 2002). Individuals with COD in general population in New York prisons should be

provided with more opportunities and programs for integrated treatment services as well as a program facilitated by qualified mental health and substance abuse counselors or program assistants.

Furthermore, COD participants in GP IDDT programs often lack an extensive aftercare component critical to their success and recovery. A reoccurring theme among inmate survey respondents in the GP IDDT program at Arthur Kill Correctional Facility was that they received inadequate discharge planning services or none at all. One inmate survey respondent stated that he "had to contact other treatment agencies myself" and had "no help from staff for outpatient counseling." Discharge planning in a correctional setting can be even more challenging for COD individuals than for inmates with no or single diagnoses, and assisting these individuals to adequately prepare for their reentry into society is essential (Smith, Sawyer, & Way, 2002). Some jail-based programs in other jurisdictions have adopted an integrated approach to service coordination and community referrals, including a treatment team comprised of corrections counselors, community treatment providers, forensic case managers and probation officers (where applicable) that communicates regularly with a re-entry liaison to plan a COD inmate's transition back into the community (Rothbard et al., 2009).

Survey Participants Assessment of IDDT Services

Over the course of the project, the CA visited four IDDT programs (both ICP IDDT and GP IDDT) with a combined capacity of 103 inmates. It sent out 70 surveys to treatment participants in these programs and received 26 surveys in return: Arthur Kill (11), Mid-State (11), Sing Sing (3), and Wende (1). In addition, the CA was able to conduct short interviews with IDDT treatment participants during the visit. While the CA realizes that the project did not have sufficient data to conduct a significant quantitative analysis, many inmate comments and survey responses still merit consideration. Several inmates in GP IDDT programs who communicated with the CA reported feeling dissatisfied and disengaged with their treatment due to their lack of involvement in their own treatment process. Some participants noted that they either did not have a treatment plan or were not consulted in the development of their treatment plan, and felt as though their goals were pre-established by program staff rather than by their personal treatment needs and objectives. Alternately, inmates in some ICP IDDT programs, administered by both

OMH and DOCS staff, reported that staff were more engaged and provided more individual attention to inmates than general population substance abuse treatment program staff. The ICP IDDT survey participants also expressed greater satisfaction with their treatment program and had more positive assessments of the effectiveness of communication within their program than the responses from GP IDDT program participants.

Conclusion

Although the CA applauds DOCS and OMH efforts to provide integrated treatment for COD inmates, at present, there are insufficient treatment slots to meet the demand for these services, particularly for COD inmates in general population. In addition, meaningful treatment programs for COD disciplinary inmates should be implemented at the many disciplinary units throughout the Department that only provide a cell-study program consisting of a treatment-readiness workbook. Disciplinary COD inmates with an active substance abuse problem should be prioritized for enrollment in substance abuse treatment in the disciplinary units.

Regardless of the treatment setting (residential, disciplinary, or general population), the CA recommends that prison staff members implementing substance abuse treatment programs should be required to undergo mental health training to better meet the needs of their COD participants. This will necessitate improved collaboration between DOCS treatment staff and OMH providers. Staff members operating the specialized IDDT substance abuse treatment programs, whether in the ICP or general population, in particular should be mental health professionals cross-trained in both substance abuse and mental health practices.

Finally, effective discharge planning for COD inmates completing prison-based treatment should be developed, both for those who will remain incarcerated and those returning home. Prison aftercare programs should be developed for these individuals and greater coordination with community-based

treatment providers will be needed to improve continuity of care for individuals with COD being released from prison.

Authors' note: *Cindy Eigler, LSMW, was the Associate Director of Special Projects for the Prison Visiting Project (PVP) of the CA and the report's principal author; Jack Beck, JD, is the Director of PVP and the principal investigator for the substance abuse study; Darcy Hirsh, JD, is the Associate Director of General Monitoring for PVP and provided significant editorial assistance for the CA report; and Elia Johnson is an intern for PVP and assisted in the preparation of this article.*

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